STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145387	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony's Nsg & Rehab Ctr	767 30th Street Rock Island, IL 61201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to initiate a skin assessment upon admission, failed to initiate admission wound orders and failed to initiate an appropriate wound care plan for one resident (R1) with a sacral pressure wound of three residents reviewed for pressure wounds. This failure resulted in R1 acquiring a Stage IV necrotic sacral pressure ulcer. Findings include: Facility Policy/Pressure Ulcers/Skin Integrity/Wound Management (undated) documents: A system is in place for the prevention, identification, treatment, and documentation of pressure and non-pressure wounds. Procedure Upon Admission: A head to toe skin assessment will be conducted by a licensed nurse. It is recommended that this assessment is completed within the shift that the resident was admitted ; however, it must be completed within 24 hours of admission. It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission, and that the factors that may have influenced its development, the potential for development of additional ulcers, or the deterioration of the pressure ulcer(s) be recognized, assessed, and addressed. Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for or who have loss of skin integrity will receive the appropriate treatment/services which may include: Specific physician ordered medications/treatment Documentation Re: Assessment History of pressure ulcers For a resident who was admitted with a pressure ulcer or who developed one within two days, the admission documentation should include at least the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Ulcer site and characteristics at the time of admission, including measurements; Possibility of underlying tissue damage because of immobility or illness prior to admission; Skin condition on and within a day of admission if suspected deep tissue injury. Care Planning: For new admission/readmissions, an immediate plan of care will be developed to address the immediate interventions to preserve and/or treat skin integrity issues. This should be communicated to staff. The care plan should address prevention of any skin breakdown, including shearing or friction, repositioning, offloading; pressure relief equipment; and the care and treatment to be provided to the resident for a pressure ulcer or non-pressure wound behaviors and characteristics. If a resident refuses or resists staff interventions, the care plan should reflect efforts to seek alternatives as well as education to resident and/or family regarding the risks. This education should be documented. All care plan interventions should be revised if there is recurring pressure ulcers, a lack of progress toward healing, or if the resident acquires a new ulcer. Physician Orders dated 10/18/24 indicates R1 was transferred from an out-of-state VA (Veterans Administration) hospital to a Skilled Nursing Facility (previous facility) on that date. Skilled Nursing Facility Progress Notes dated 10/19/24 at 9:41pm indicate R1 had Small sheared area under scrotum and coccyx with shearing and multiple small open areas. Initial (Physician) Wound Evaluation & Management Summary dated 10/21/24 indicates R1 with a History of Stage IV sacral pressure wound/full thickness Now with scattered areas with minimal depth. Summary indicates wound size 6cm (centimeters) x 6cm x 0.1cm; cluster wound with open ulceration area; light serous exudate; 80% granulation tissue; 20% intact normal color skin. Summary Treatment Plan/Primary Dressing: Zinc ointment to affected area twice daily and as needed. for 30 days. Skilled Nursing Facility Physician Orders indicate R1 had the following orders upon discharge and transfer (10/24/24) to current facility: Cleanse sacral area with soap and water and apply Zinc twice daily and as needed (order date 10/21/24). Facility Admission (10/24/24) Physician Orders indicate wound care orders for R1 were not initiated until 11/1/24. TAR (Treatment Administration Record) dated 11/1/24 indicates sacral wound treatment was initiated on that date after R1 was seen by Wound Physician on 11/1/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1 received no wound treatment from 10/24/224 to 11/1/24. No admission skin assessment was found or presented after R1 was admitted to the facility on [DATE] until 11/1/24. On 4/1/25 at 2:45pm V2, DON (Director of Nursing) confirmed a skin assessment was not completed upon admission for R1 and acknowledged the first skin assessment completed for R1 was provided by V6, Wound Physician on 11/1/24. Telemedicine Wound Care Follow Up Evaluation dated 11/1/24 indicates R1 sacral pressure wound as full thickness Stage IV: Wound Size: 9.0cm x 8.5cm x not measurable Depth not measurable due to presence of nonviable tissue and necrosis. Periwound Radius: Surrounding DTI (Deep Tissue Injury) Moderate serous exudate Thick adherent black necrotic tissue (eschar): 100% Wound Progress: Exacerbated due to unknown since admission to facility on 10/24/24. Wound Evaluation Treatment Plan dated 11/1/24 included: Initiate Leptospermum Honey once daily for 30 days, cover with foam silicone border for 30 days. No sharp debridement due to Telemedicine visit. Wound Evaluation and Management Summaries dated 1/16/25, 12/19/24 and 11/20/24 indicate R1 received surgical debridement of his sacral wound by V6, Wound Physician on those dates. Telemedicine Wound Care Follow Up Evaluation dated 1/23/25 indicates R1 sacral pressure wound as full thickness Stage IV with healing potential as Poor with following description: Wound Size: 12.4cm x 10.1cm x 0.2cm Periwound Radius: Erythema, Induration Moderate serous exudate Thick adherent black necrotic tissue (eschar): 100% Wound Progress: Exacerbated due to infection. Wound Evaluation Treatment Plan dated 1/23/25 included: Off-load wound; reposition per facility protocol; antibiotic choice: Cipro 750mg (milligram) once daily and Metronidazole 500mg three times per day x 7 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Progress Note dated 1/23/25 at 10:16am R1 colostomy with no BM (Bowel Movement) noted this shift. NP (Nurse Practitioner) made aware and notified, R1 sent to ED (Emergency Department). Progress Note dated 1/23/25 at 10:54am indicates Notified POA (Power of Attorney) of (R1) transfer to ED and change in condition. Hospitalist Progress Note dated 1/28/25 indicates: Patient (R1) is [AGE] year-old male who has significant past medical history of including but not limited to diabetes type 2, coronary artery disease, hypertension, history of colostomy, status post C2-T4 spinal fusion with laminectomy C2-C3, vertigo, paraplegia, neurogenic bladder with indwelling urinary catheter, history of brain bleed, patient was sent to the emergency roiagnom on [DATE] from nursing care facility with chief complaint of low urine output. As per information from the chart, patient (R1) was recently diagnosed with UTI (Urinary Tract Infection). On further evaluation it was also noted that patient (R1) has a large sacral pressure ulcer, foul-smelling (pictures in the chart). Patient was admitted . Patient (R1) underwent excisional debridement of sacral wound in preparation for flap closure on January 27, 2025. Hospital Palliative Care Note dated 1/29/2025 LOS (Length of Stay) 5 days: Massive wounds. stage IV pressure ulcer located on his sacrum, stage III pressure ulcer located on his scrotum and a stage III pressure ulcer located on his right ischium. ID (Infectious Disease) discussed with R1's family that the best case scenario of R1 going to a tertiary care center where there is a plastic surgery/general surgery and grafting and in the best cases this heals versus wound care recurrent infection, and this does not heal. Discussed comfort care hospice care limited care. R1's Care Plan indicates Problem Area date initiated and revised 10/28/24 indicates Alteration in skin integrity - location coccyx. Identified on admission. Care Plan indicates Initial size and stage - see wound notes. All Interventions were initiated on 10/28/24 and are as follows: Refer to Nurse Practitioner as appropriate Dietary consult as indicated Turn and reposition routinely. Document any refusal. R1's care plan was never reviewed, revised or updated despite wound deteriorating, debridement by wound physician and did not include any pressure relief equipment, changes in treatments or subsequent wound infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/1/25 at 3:10pm V7, NP (Nurse Practitioner) stated I did not actually visualize (R1's) wound when he was here. I was doing physiatry - not wounds at that time. I knew he came in with a wound. He was previously at another local facility. (R1) was being followed by wound physicians at (the previous facility) so it was continued when he came here. I would never have recommended debridement for that wound. It was too extensive. I had no idea it was that big. I'm surprised they debrided it in the hospital. V7 stated R1 was very non-compliant with care and resistive to weight shifting, offloading when he was at this facility. V7 stated R1 was also verbally aggressive, cussing staff out. V7 stated (R1) would never have complied with precautions or interventions after debridement. It would have ended up infected. V7 stated that R1's care plan should have included his non-compliance with wound care interventions. On 4/2/25 at 1:18pm V4, Wound Physician stated R1 did not have eschar on his sacral wound when she saw him on 10/21/24 (prior to facility admission on 10/24/24). V4 acknowledged she recommended Zinc for R1's wound at that time and stated, Zinc is not an appropriate treatment for a wound with eschar. V4 stated that she ordered Zinc because the wound had low drainage and would protect fragile skin. V4 stated I doubt if not having Zinc for a week would lead to a wound covered in 100% Eschar - so there must have been more factors at play. The order for Zinc twice daily should have been carried over though or re-evaluated upon admission.